Patient Information and Consent

Welcome and thank you for considering Sesi Signature Inc. ("Sesi Signature Inc.", "us", "Company") for your medical needs. This document contains important information about our professional services and business policies.

Licensed Healthcare Provider

The Healthcare Provider is engaged in private practice providing medical care services to clients on behalf of the Company and not personally. In addition, all staff of the Company are providing services in their capacity under the Company and not personally.

Appointment and Cancellation Policy

Appointments may be scheduled by calling (714)-905-5900 during business hours listed at {{Website}}. Patients must cancel or reschedule at least 24 hours in advance to avoid charges and potential discharge. Missed appointments are typically not reimbursed by third-party payers. Missed or late appointments will be charged in full, and fees will not be pro-rated. If the provider cancels, a refund or rescheduling will be offered. Patients who miss or fail to cancel three (3) appointments may be discharged from services at the Company's discretion.

Visit Frequency and Duration

The number and frequency of sessions are based on individual needs and will be determined by the healthcare provider. The initial visit typically includes an evaluation and lasts 60 to 90 minutes; follow-up visits generally range from 15 to 45 minutes. Some assessments may extend visit time, and total visit length includes both face-to-face care and provider documentation.

Additional evaluation sessions may be required before a treatment plan is established. If both the patient and provider agree to proceed, the provider will outline a plan of care. Patients should consider whether they feel comfortable working with the provider, as medical services require a significant commitment of time, energy, and cost. Questions are welcome at any time, and patients may request support in obtaining a second opinion from another licensed medical professional.

Note: A responsible adult must be present during all visits for minors; drop-offs are not permitted.

Informed Consent for Medical Procedures

By signing this form, I acknowledge and consent to the following:

1. Disclosure of Medical Information

- I have informed the healthcare providers at Sesi Signature Inc. of any known allergies to medications or other substances.
- I have disclosed all medications, supplements, and relevant parts of my medical history, even if not specifically requested.

2. Procedures and FDA Status

- I understand that while many of the procedures offered atSesi Signature Inc. are medically recognized and commonly practiced, some treatments may involve the use of products or devices that are used "off-label" (i.e., for indications not specifically approved by the U.S. Food and Drug Administration).
- I acknowledge that certain procedures may not be FDA-approved for the specific use or indication being addressed, and I have been informed of this where applicable.
- These procedures are provided as part of my overall care plan and are not intended to replace necessary medical treatment provided by my primary care provider or other specialists.

3. Right to Information

- I understand I have the right to receive an explanation of the procedure(s), the risks and benefits, and any available alternatives.
- Except in emergencies, no procedures will be performed without my informed consent.

4. Consent to Treatment

- I confirm that I have received and understood the information I desire concerning the procedures.
- I voluntarily authorize and consent to the performance of any procedures recommended to me by the healthcare providers at Sesi Signature Inc..

5. Release of Liability

- I release Sesi Signature Inc., its healthcare providers, staff, and agents from any liability for complications or damages associated with procedures I choose to undergo.

Payment for Services

The fees for our services are listed below (or attached on a fee schedule):

A - $100 (TeleConvenient Visit)

B - $150 (TeleConvenient Monthly Membership)

D- (Family Discounts for memberships will also be available).

D- (Any additional service fees will be determined on a case-by-case basis and mutually agreed upon by the patient and provider in advance).

These fees are subject to change upon thirty (30) days' prior notice to you. If you are unable to pay, or are not willing to pay, the higher fee after receipt of notice, services may be terminated and you may be given referrals to other competent providers. The Healthcare Provider will look to you for full payment of your account, and you will be responsible for payment of all charges. Different copayments are required by various group coverage plans. Your copayment is based on the Medical Policy selected by your employer or purchased by you. In addition, the co-pay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the Healthcare Provider's charges for services at the time the services are provided, unless there is applicable insurance coverage in force. It is recommended that you determine your copayment before your first visit by calling your benefits office or insurance company.

Legal Testimony & Record Disclosure Policy

Although it is the goal of the Healthcare Provider to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the Healthcare Provider's testimony are requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the Healthcare Provider at the time of the request or service of the subpoena (current rate is $450/hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the Healthcare Provider. The Healthcare Provider may require a deposit for anticipated court appearances and preparation. You will not be entitled to a pro-rated refund.

To the fullest extent permitted by applicable law, the Patient agrees that the Provider’s services are provided solely for the purposes of medical care and treatment, and not for the purpose of serving as an expert witness, consultant, or providing testimony in any legal, administrative, or judicial proceeding. The Patient expressly waives any right to compel the Provider’s participation in such proceedings, including, but not limited to, subpoenaing or requiring the Provider to testify as an expert or fact witness; provide depositions, affidavits, or declarations; or

participate in any manner in legal or quasi-legal proceedings initiated by the Patient or on the Patient's behalf.

This clause shall not apply where the Provider's participation is mandated by law, regulation, or court order. In such cases, the Patient agrees to reimburse the Provider for any reasonable costs, time, and expenses incurred as a result of compliance with such legal requirements, including an hourly rate for the Provider's professional time, as stated within this Agreement.

Mandated Reporting

Persons in designated professional occupations are mandated to report suspected child abuse or neglect or maltreatment of vulnerable adults. Persons who work with children and families are in a position to help protect children from harm. These persons may be required by law to report, if they know or have a reason to believe that a child or vulnerable adult is being abused or neglected. As a mandated reporter, the healthcare provider may be required to break confidentiality and report certain information to the appropriate authorities.

Risks of Services

There are no guarantees in services and the Healthcare Provider does not make any guarantees with this agreement. You assume the risk of services by signing this form. The Healthcare Provider is not liable for any adverse reactions to services. The Healthcare Provider may take any reasonable action necessary during services when there is a dangerous circumstance, as determined by the Healthcare Provider. You agree to mitigate this risk by disclosing any and all relevant medical information to the Healthcare Provider

Emergencies

Sesi Signature Inc. and your Healthcare Provider do not provide 24/7 emergency services. For any medical emergency, call 911 or go to the nearest emergency room. If you are experiencing suicidal thoughts or safety concerns, follow your harm reduction plan if available, then contact 911 or seek emergency care.

Contacting Your Healthcare Provider

Your healthcare provider is often not immediately available by telephone. The office number 133-657-0712 is answered by voicemail that the Company will monitor from time to time throughout the day. Although the healthcare provider is typically in the office during normal business hours they will not take calls when with a client. There is no guarantee of a response time or a response at all. The best time to reach your healthcare provider is at the next scheduled appointment.

E-Mail and Text Messages

Sesi Signature Inc. and its healthcare providers may use email or text messages only for administrative purposes, such as scheduling or modifying appointments. These methods are not appropriate for discussing treatment or clinical matters, and such topics will be addressed during scheduled sessions. Electronic communications are not fully secure or confidential. Messages sent via email, text, or social media platforms may be stored by your service providers and could be accessed by system administrators. Patients who choose to communicate electronically acknowledge and accept the risks associated with insecure transmission.

Social Media

Your healthcare provider generally does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the healthcare provider and the client. It can blur the boundaries of the professional relationship. Business pages or social media business pages are an opportunity for you to voluntarily follow the Company, if you choose.

Audio and Video Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you nor the Company will record any part of your medical procedures or services unless you and the Company mutually agree in writing that the medical procedures or services may be recorded, such as a valid testimonial or before-and-after photo. You further acknowledge that the Company and its healthcare providers and staff object to you recording anything related to their services or work without written consent. You expressly agree that audio and video recordings used for security purposes are not part of medical services, and are therefore not protected by confidentiality or any other provisions under this agreement.

Transfer of Records in Case of Healthcare Provider Incapacity or Death

In the event that the treating Healthcare Provider becomes incapacitated or passes away, I acknowledge that it may be necessary for another licensed healthcare professional to take custody of my medical file and records. I authorize Sesi Signature Inc. to designate a qualified successor healthcare professional for this purpose. This successor healthcare professional may take possession of my records, provide me with copies upon request, and transfer records to another provider of my choosing upon my written request. This transfer is intended to ensure continuity of care and compliance with all applicable privacy and medical record retention laws.

Legal

This Agreement shall be construed in accordance with, and governed by, the laws of the State of California as applied to contracts that are executed and performed entirely in California. The exclusive venue for any court proceeding based on or arising out of this Agreement shall be in California in the county of incorporation of the Company. The parties agree to attempt to resolve any dispute, claim or controversy arising out of or relating to this Agreement by arbitration, which shall be conducted under the then current arbitration procedures of the American Arbitration Association any other procedure upon which both the parties may agree. The parties further agree that their respective good faith participation in arbitration is a condition precedent to pursuing any other available legal or equitable remedy, including litigation, arbitration or other dispute resolution procedures. If any legal action or any arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, the Company shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action or proceeding, in addition to any other relief to which it or they may be entitled.

Consent to Treatment

I, voluntarily, agree to receive (or agree for my child to receive) Medical assessment, care, treatment, or services, and authorize Sesi Signature Inc. to provide such care, treatment, or services. I understand that I am not guaranteed a positive outcome. I agree to follow the agreed upon treatment plan and to inform Sesi Signature Inc. if I alter my treatment plan, experience side effects, or cease to follow my treatment plan.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through Company at any time.

By signing this Client Information and Consent form, I, the undersigned client (or parent/ guardian), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I acknowledge that I received a copy of this signed information and consent form from my mental health professional on the date listed below.

My signature indicates that I am the legal parent or guardian of the above named minor and that I am allowing my child to be treated at the Company in the event of an accident, injury, illness, or other medical condition. I understand that I am responsible for all costs incurred and that an

insurance ready bill will be provided for me to submit to my insurance company. I recognize that I have the right to revoke this consent and that this consent is not needed when the above named individual reaches the age of consent or applicable law in my State and meets any of the conditions identified above.

Client/Parent/Guardian 1 Signature: _____

Date: _____

(If client is a minor and parents are separated)

Parent/Guardian 2 Signature: _____

Date: _____

Parental Waiver of Right to Child's Records [Optional]

I hereby waive my right as parent/guardian to obtain information from and copies of any records from Company pertaining to the assessment, evaluation, and treatment of my child. I understand that Company may refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's mental health professional would negatively impact the child or the child's evaluation and treatment. I hereby release Company and its agents from any and all liability for good-faith refusal to disclose the child's information or records.

Parent 1/Guardian Signature: _____

Date: _____

Parent2/Guardian Signature: _____

Date: _____